MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Princeton Pain Mgmt 3710 Rawlins Dallas TX 75219	MDR Tracking No.: M4-03-7455-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Insurance Co. of the State of PA c/o Flahive, Ogden 505 W. 12th Street Austin TX 78701	Date of Injury: Employer's Name: Sodexho, Inc. Insurance Carrier's No.: 023050000111060001

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/3/03	2/11/03	97799CP	$10,920.00	$0.00
3/5/03	3/5/03	90844	$122.00	$122.00
3/19/93	3/19/03	90904, 90906	$240.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

5/1/03: "Please find enclosed documentation regarding unpaid bills for services rendered…carrier denied our bills twice for medical necessity. We obtained preauthorization…copy of the approval letter is enclosed…we are requesting reimbursement…for the full amount billed…"

PART IV: RESPONDENT'S POSITION SUMMARY

6/25/03: "This letter is filed in response to the MDR…This dispute involves DOS 2/3/03 through 3/19/03…Carrier denied payment as unnecessary treatment, "U". The provider's preauthorizations do not match the services rendered during the relevant time period of the approval. For example, carrier approved 15 units of physical medical/rehabilitation, but the services were billed as chronic pain management (97799-CP). While the carrier approved the 15 units of physical…it did not approve pain management as medically necessary…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-CP, for DOS 2/3/03 through 2/11/03 were denied as "U- (F) Chronic Pain Management, Unless otherwise specified, all fee reductions are in accordance with the TWCC reimbursement manual which was in effect on the DOS." Per the MFG / MGR (II)(G)(9), DOP is required. According to 133.1(a)(8) usual and customary charges were not established with convincing evidence, therefore reimbursement can not be recommended.
- CPT Code 90844, for DOS 3/5/03 was also denied as "U- (F) Chronic Pain Management, Unless otherwise specified, all fee reductions are in accordance with the TWCC reimbursement manual which was in effect on the DOS." The requestor obtained preauthorization on 2/24/03 for "Individual Med. Psychotherapy-Phys, approx 45-50 min and Biofeedback Training by Any Modality Pharm Mgmt w/script use and Review-min Psychotherapy." Per the MFG CPT code descriptor and MFG/MGR (II)(F)(3,b), reimbursement is recommended as billed, amount due $122.00.
- CPT Codes 90904, 90906 for DOS 3/19/03 were denied for "F – The charge for this procedure exceeds the fee schedule or unusual and customary allowance. Fee reductions are in accordance with the TWCC

reimbursement manual which was in effect on the DOS." As previously stated for Code 90844, preauthorization was obtained for Biofeedback. The medical documentation did not substantiate the amount billed according to the MFG descriptor or MFG/MGR (II)(G)(4), therefore reimbursement is not recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $122.00__. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	3/13/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____